Wyoming Medicaid Expansion Analysis

Results Summary

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EXECUTIVE SUMMARY

Milliman was engaged by the Wyoming Department of Health (WDH) to conduct a study to summarize historical enrollment and cost trends for Wyoming Medicaid, and to develop projections of enrollment and costs for the current program and the expansion of the program under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together commonly referred to as the Affordable Care Act (ACA), starting in 2014.

Approximately 70,000 people were enrolled in Wyoming Medicaid as of June 2011, with approximately 90,000 people enrolled at some point during FY 2011.[1] More than 70% of enrolled members were in the Children or Family Care Adult categories, with children outnumbering adults by roughly seven-to-one. In spite of their large populations, these categories account for only about one-third of total state Medicaid spending; disabled members and HCBS waiver recipients account for the majority of costs in spite of constituting only about one-sixth of total membership.

Starting in 2014, the ACA will allow Wyoming to expand its Medicaid program to cover adults under age 65 with incomes up to 133% of the federal poverty level (FPL) irrespective of family status, disability, pregnancy, or other factors. Additionally, the ACA will require Wyoming to expand its Medicaid program to cover children up to 133% of the FPL; this expansion of coverage is not optional.[2] This report uses publicly available data sources, Wyoming Medicaid claim and enrollment data provided by the Wyoming Department of Health, and Milliman tools to develop projections for how many new members may enroll in Wyoming Medicaid starting in 2014 and the estimated cost of this population.

On June 28, 2012, the United States Supreme Court ruled that the federal government may not withhold funding for the currently existing Medicaid program solely because a state does not comply with the ACA's expansion of Medicaid. In light of the optional nature of Medicaid expansion under the ACA for the adult population, we provide a breakout of enrollment and costs associated with the adult expansion population, the "woodwork" population that is already eligible for Medicaid but not currently enrolled (but who will likely enroll in 2014 due to the individual mandate under the ACA or increased awareness of insurance options), and the newly eligible child population that must be covered.

If the ACA's Medicaid expansion is fully implemented in Wyoming, we project new enrollment of approximately 16,800 to 44,500 total actively enrolled members as of the end of 2016 in addition to growth that would have occurred without the ACA expansion (see Table 1); our best estimate is approximately 28,200 new members enrolled as of the end of 2016, with approximately 3,700 of these members coming from the "woodwork" population. We estimate that if the lower end of the expansion enrollment range is realized, the cost to the State of providing Medicaid services will be a total of $53 million to $68 million from FY 2014 to FY 2020. If the high end of the expansion enrollment range is realized, our total cost estimate is $245 million to $311 million paid by the State during that period. If our best estimate for enrollment is realized, we project state costs for the expansion population of $116 million to $148 million from FY 2014 to FY 2020, with approximately $48 to $60 million of these costs coming from the "woodwork" population. Cost projections for our best estimate scenario are presented in Table 2. Projections for alternate scenarios are shown in the tables in Appendix A. Except where indicated otherwise, the cost projections in this paragraph are for the full ACA expansion; the tables in this report indicate the proportion of this total attributable to the woodwork population, expansion adult population, and the newly eligible newly eligible child population. The amounts in this paragraph **do not** include administrative expenses; see page 5 for further discussion of administrative expenses.

[1] Wyoming Department of Health, Wyoming Medicaid Annual Report: State Fiscal Year 2011, p. 2, available online: http://www.health.wyo.gov/healthcarefin/equalitycare/index.html

[2] Our understanding is that the Supreme Court's June 28, 2012, ruling did not remove the obligation of states to expand Medicaid to children who meet the ACA's income test because 42 U.S.C. § 1396a(l), where this is required, is not part of the specific Medicaid Expansion section changed by the Supreme Court decision. See Kaiser Family Foundation, "Implementing the ACA's Medicaid-Related Health Reform Provisions After the Supreme Court's Decision," August 2012, available online: http://www.kff.org/healthreform/upload/8348.pdf.

These costs would be in addition to the costs of providing services under Wyoming Medicaid as it exists today; we estimate that current program costs would range from $2.2 billion to $2.8 billion from FY 2014 to FY 2020. All costs described above represent expenditures *by the State of Wyoming*. The Federal government also pays for a portion of Medicaid expenses in addition to the amounts just cited; the current federal match rate is 50%, but a higher match rate would apply to the adult expansion population newly enrolled under the ACA's provisions (starting at 100% in 2014 and declining to 90% by 2020). If our best estimate for enrollment is realized, we project federal costs for the full ACA expansion (woodwork, expansion adults, and newly eligible children) of $771 million to $968 million from FY 2014 to FY 2020 (see Appendix A, tables A2 and A3).

Our principal results are presented in the tables below. Table 1 displays our estimates for additional enrollment due to expanding Medicaid as described in the ACA.

Table 1 – Summary of Projected Wyoming Medicaid Full ACA Expansion Population[3]

Population Segment, By Pre-2014 Insurance Status	Low Enrollment Scenario	Best Estimate Scenario	High Enrollment Scenario
Wyoming Medicaid Full ACA Expansion by 2016 (assuming full expansion)	16,800	28,200	44,500
Woodwork, Adults and Children (Not Optional)	700	3,700	10,800
Expansion Adults	11,500	17,600	22,900
Uninsured in 2013, not previously Medicaid-eligible, elects Medicaid	8,700	12,900	14,800
Private individual or group insurance	2,800	4,600	8,000
Near-poor, deliberately lowers income to qualify for Medicaid	0	100	200
Newly Eligible Children (Not Optional)	4,600	6,900	10,800
Private individual or group insurance	2,900	4,600	8,000
Near-poor, deliberately lowers income to qualify for Medicaid	<100	<100	100
Children ages 6-18 transferred from Kid Care CHIP to Medicaid	800	1,000	1,300
Already eligible for CHIP (but not enrolled) and newly enrolled in Medicaid in 2014	1,000	1,200	1,400

Table 2 displays our estimates for the state and federal portions of the cost of providing Medicaid services to the full ACA expansion population. The table displays total healthcare costs from state fiscal years 2014 to 2020. Additional detail showing spending projections by fiscal year can be found in the tables in Appendix A.

[3] Population estimates in this table are rounded to the nearest 100. Due to rounding, the grand total displayed is not always exactly equal to the sum of the rows above.

Table 2 – Total Projected Cost for Full ACA Medicaid Expansion for FY 2014 to FY 2020 ($MM)			
	State Share	**Federal Share**	**Total**
Woodwork Population (Not Optional)	**$8.7 to $173.6**	**$8.7 to $173.6**	**$17.3 to $347.1**
Low enrollment	$8.7 to $10.8	$8.7 to $10.8	$17.3 to $21.7
Best estimate enrollment	$47.6 to $59.7	$47.6 to $59.7	$95.2 to $119.3
High enrollment	$138.5 to $173.6	$138.5 to $173.6	$276.9 to $347.1
Expansion Adults	**$20.0 to $58.5**	**$429.9 to $1,117.3**	**$449.9 to $1,175.8**
Low enrollment	$20.0 to $26.5	$429.9 to $539.1	$449.9 to $565.6
Best estimate enrollment	$31.0 to $41.1	$658.5 to $825.9	$689.5 to $867.0
High enrollment	$44.3 to $58.5	$890.7 to $1,117.3	$935.0 to $1,175.8
Newly Eligible Children (Not Optional)	**$24.6 to $78.7**	**$45.6 to $124.9**	**$70.2 to $203.6**
Low enrollment	$24.6 to $31.0	$45.6 to $57.5	$70.2 to $88.6
Best estimate enrollment	$37.6 to $47.4	$65.2 to $82.4	$102.8 to $129.8
High enrollment	$62.5 to $78.7	$98.9 to $124.9	$161.4 to $203.6
Total (Full ACA Expansion)	**$53.3 to $310.8**	**$484.2 to $1,415.8**	**$537.4 to $1,726.5**
Low enrollment	$53.3 to $68.3	$484.2 to $607.4	$537.4 to $675.9
Best estimate enrollment	$116.2 to $148.2	$771.3 to $968.0	$887.5 to $1,116.1
High enrollment	$245.3 to $310.8	$1,128.1 to $1,415.8	$1,373.3 to $1,726.5

Table 2 cost estimates are for healthcare only; these estimates do not include administrative expenses. In our experience, administrative costs for a Medicaid program typically are between 3.5% and 6.0% of healthcare costs. Expansion of Medicaid likely would cause an increase in administrative costs due to growth in membership and associated costs of managing enrollment, processing claims, and performing other overhead functions. Because these populations will be adults and children who typically have lower claim costs than aged, blind, and disabled (ABD) members, our best estimate for administrative costs is 4% of the amounts shown in Table 2 above. For our best estimate, this would total approximately the following amounts from FY 2014 to FY 2020:

- $4.3 million for the woodwork population
- $30.9 million for the adult expansion population
- $4.6 million for the newly eligible children population

These are total administrative costs; states generally receive an FMAP of 50% for administrative costs,[4] meaning that half of these amounts would be covered by the federal government.

Table 2 also does not take into account possible cost offsets to other state-funded programs. We expect that some of the newly eligible members enrolled in Wyoming Medicaid starting in 2014 will be people who would have otherwise been eligible for other state-funded programs. This would result in reduced enrollment and costs for those programs, offsetting some of the cost of Medicaid expansion to the State. Currently covered members of Wyoming's Prescription Drug Assistance Program (PDAP) would become eligible for Medicaid starting in 2014 due to the expanded income threshold. Medicaid expansion under the ACA would also likely reduce the general fund outlay for the Wyoming State Hospital. An enhanced Federal Medical Assistance Percentage (FMAP) will reduce the State's total expenditures for

[4] Congressional Research Service, "Medicaid: The Federal Medical Assistance Percentage (FMAP)," 25 March 2010, p. 1.

Kid Care CHIP; the legislation provides for an additional federal matching rate of 23 percentage points on top of the existing 65% FMAP for CHIP beginning on October 1, 2015, and ending September 30, 2019, which will increase the Wyoming CHIP FMAP to 88%. Other programs could be reduced or serve fewer members starting in 2014, including Wyoming Medicaid's breast and cervical cancer coverage, behavioral health outpatient services, the Wyoming Colorectal Cancer Screening Program (WCCSP), the children's marginal dental program, and state-funded health coverage for foster care children not currently eligible for Wyoming Medicaid.

Projections for future costs and enrollment are subject to considerable uncertainty. The results presented in this report should be understood in light of the caveats and limitations described on page 32, with consideration given to the sensitivity of our assumptions.

INTRODUCTION

This report presents Milliman's analysis of the impact of the Medicaid expansion in the Patient Protection and Affordable Care Act (ACA) on Wyoming's Medicaid program.

The ACA was signed into law by President Obama in March 2010 and includes a number of provisions to expand Medicaid in an attempt to reduce the number of uninsured citizens. The new provisions require that Medicaid enrollment be offered to all individuals under age 65 with incomes less than or equal to 133 percent of the federal poverty level (FPL) plus a 5 percent disregard.[5] In Wyoming, this will mean extending Medicaid benefits to adults who meet the new income requirement (including adults without dependent children), and children ages 6 to 18 with a familial income between 100 and 138 percent of the FPL. These new provisions will increase the number of adults who qualify for Wyoming Medicaid in the Family Care eligibility program, add a new eligibility program for adults without dependent children, and they will also cause some of the children who currently participate in Kid Care CHIP to be moved to the Wyoming Medicaid program. For the newly eligible population, a higher Federal Medical Assistance Percentage (FMAP) will apply than the match rate available to current programs; the federal match rate will be 100% in 2014, and decline to 90% by 2020. This higher match applies to adults newly eligible under the ACA; it would not apply to children and to members already eligible. Based on currently available information, it is our understanding that children who currently are eligible for CHIP (but not Medicaid), regardless of whether they are currently enrolled in CHIP, would receive the CHIP FMAP starting in 2014 rather than the Medicaid FMAP that applies to children. This is discussed further in the Projected Cost of Full ACA Medicaid Expansion section of this report.

On June 28, 2012, the United States Supreme Court ruled that the federal government may not withhold funding for the currently existing Medicaid program solely because a state does not comply with the ACA's expansion of Medicaid to the targeted adult population. The purpose of this report is to project enrollment and costs if Wyoming does expand Medicaid as outlined in the ACA. Accordingly, we have not considered the implications of electing not to expand Medicaid as outlined in the ACA and make no recommendation as to whether Wyoming should or should not avail itself of the option apparently provided by the Supreme Court's June 28, 2012, decision.

Throughout this report:

- "Fiscal Year" (abbreviation FY) refers to a 12-month period ending June 30, corresponding to Wyoming's state fiscal period. For example, FY 2011 means July 1, 2010, to June 30, 2011. Where we intend to refer to the federal fiscal year (which ends September 30), we state so specifically.
- The federal poverty level (FPL), as of calendar year 2012, is $11,170 for a one-person household. It rises by $3,960 for each additional household member (e.g., the FPL for a family of four is $23,050). The federal government adjusts FPL annually for inflation.[6]
- We use 138% as the percentage of FPL to which Medicaid enrollment must be extended. While 133% is often cited as the upper limit, there is a 5% income disregard.
- We have assumed that Wyoming will not offer a Basic Health Plan, which is an option under the ACA. Under this provision,[7] states may choose to provide coverage for qualifying individuals with incomes between 133-200% FPL

[5] This disregard was introduced into the law through H.R. 4872, the Health Care and Education Reconcilliation Act of 2010 (commonly referred to as the "Reconcilliation Act"). By "disregarding" 5% of income, the income cutoff to qualify for Medicaid is effectively raised from 133% to 138% of the FPL.

[6] Federal Register, Vol. 77, No. 17 (January 26, 2012), pp. 4034-35.

[7] ACA Sec. 1331. State Flexibility to Establish Basic Health Programs for Low-Income Individuals not Eligible for Medicaid

who would otherwise receive premium subsidies in the Exchange. The Basic Health Plan must provide at least the Essential Health Benefits outlined in the ACA, and certain premium restrictions apply. In return, states that establish a Basic Health Plan receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies.

- We have conducted both our retrospective and prospective cost analyses on an incurred (not paid) basis. The incurred date of a claim is the date the service is rendered (for example, the date of a physician office visit). The paid date of a claim is the date payment is actually made to the provider, and this date is always later than the incurred date. The time period between the two dates is known as the lag; the lag period can be short for some claims (especially pharmacy) and may be long for others (especially inpatient hospital). It is important to note that where our report projects costs in a certain time period, it does not necessarily mean that the State will release payment during the same time period. This could have budgetary implications over a specified (especially short) time period. We have prepared our report this way because it is more actuarially sound to prepare projections in this manner, since it matches total cost to total members who were enrolled at the time the charge was incurred.
- Not all eligible members utilize services during a given year (or ever). Throughout this report, the terms "eligible," "enrollee," or related forms of those words denote a person who was (or will be) enrolled in Wyoming Medicaid. These people may or may not incur any medical expenses. The term "recipient" is used to denote an enrollee who does use services.
- We have assumed that the ACA will be implemented in accordance with the statute, regulations, and court rulings existing as of the date of this report. Where we use the phrase "full ACA expansion population," we intend to include the "woodwork population" (those who are and would remain Medicaid-eligible even if Wyoming does not elect the optional expansion), newly eligible children (this new population coverage is not optional), and the adult expansion population that would become eligible only if Wyoming expands Medicaid to adults meeting the ACA's income test. Our tables separate this full ACA expansion population into these segments.

Our report is organized as follows. First, we present an overview of Medicaid in Wyoming. Second, we present the results of our analysis of Wyoming Medicaid's recent historical enrollment and claim experience. Third, we present our projections for increased enrollment starting January 1, 2014. Finally, we present our projections for the cost of the full ACA expansion population, along with projections for the cost of the Medicaid program as it exists today.

OVERVIEW OF WYOMING MEDICAID

Medicaid was first established under the Social Security Act in 1965. Broad guidelines for the nation's Medicaid programs have been established by the Centers for Medicare and Medicaid Services (CMS), but each state administers its own program. The Medicaid program in each state is jointly funded by the state and federal government. The federal government currently pays for 50% of costs associated with Wyoming's Medicaid program. This percentage was somewhat higher during parts of FY 2009 to FY 2011 due to a temporary increase from the American Recovery and Reinvestment Act.[8]

The Centers for Medicare and Medicaid Services (CMS) have outlined a list of mandatory services that must be provided by the Medicaid program in each state, but states can offer additional services at their discretion. Wyoming's Medicaid program covers the mandatory services and some optional services (examples of optional services include vision care, intermediate care facility services, and the waiver programs). Waiver programs are optional programs where Wyoming has applied for and received permission from CMS to offer specialized programs that are exempt from certain federal requirements. A more detailed description of Wyoming's waiver programs can be found in the Medicaid program's annual report.[9]

Wyoming Medicaid currently provides coverage to four broad categories of citizens: children, pregnant women, Family Care adults, and citizens who meet eligibility requirements as "aged, blind, or disabled" (ABD). A handful of other categories of people are eligible for assistance (subject to various income requirements), such as those needing assistance with Medicare premiums or cost sharing, women with breast or cervical cancer, and non-citizens (limited coverage for medical emergencies). Nearly 90,000 people were enrolled in Wyoming Medicaid at some point during FY 2011, with about 70,000 being enrolled at the end of the fiscal year.[10]

There are a variety of ways that an individual can be eligible for Wyoming Medicaid: Table 3 below outlines the eligibility criteria and restrictions for each group.

[8] FY2011: Federal Register, June 3, 2011 (Vol. 76, No. 107), pp 32204-32207. Available online: http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4

[9] Wyoming Department of Health. Medicaid Annual Report, (State Fiscal Year 2011). Wyoming: Division of Healthcare Financing. Available online: http://www.health.wyo.gov/healthcarefin/equalitycare/index.html, pages 81-104.

[10] Wyoming Department of Health. Medicaid Annual Report, (State Fiscal Year 2011). Wyoming: Division of Healthcare Financing. Available online: http://www.health.wyo.gov/healthcarefin/equalitycare/index.html

Table 3 – Wyoming Medicaid Eligibility Requirements[11]

	Criteria	Restrictions
Children	• Ages 6-18: Familial income ≤ 100% of the FPL • Ages 5 and under: Familial income ≤ 133% of the FPL	
Pregnant women	• Familial income ≤ 133% of the FPL • Presumptive eligibility provides coverage for pregnant women for up to 60 days pending eligibility determination	• If familial income is below the 1996 Family Care Standard, the woman must cooperate in establishing paternity for the child
Family care adults	•Familial income ≤ 1996 Family Care Standard[12]	
ABD	• Any citizen who receives SSI benefits • Citizens who don't receive SSI benefits but meet SSI eligibility criteria • Citizens eligible for home and community based (HCBS) waiver programs • Citizens who live in a nursing home, hospital, hospice, intermediate care facility for intellectual disabilities (ICF-ID), or a state hospital: Personal income ≤ 300 percent of the SSI standard • Qualified Medicare Beneficiaries: Personal income ≤ 100 percent of the FPL • Low Income Medicare Beneficiaries: Personal income ≤ 135 percent of the FPL • Employed individuals with disabilities: Unearned income ≤ 300% of SSI standard	• Qualified Medicare Beneficiaries who qualify for Medicaid may use it to pay for their Medicare premiums, deductibles, and cost sharing • Low Income Medicare Beneficiaries who qualify for Medicaid may only use Medicaid to pay for their Medicare premiums • Employed individuals with disabilities must pay a premium
Other special groups	• Uninsured women diagnosed with breast or cervical cancer: Personal income ≤ 250 percent of FPL • Individuals diagnosed with tuberculosis: Eligible under special income standards • Non-citizens who meet other eligibility requirements	• Non-citizens may only receive benefits for emergency services

The Wyoming Department of Health also administers a health insurance plan called Kid Care CHIP which offers a low-cost medical, dental, and vision plan to children under the age of 19. In order to qualify for Kid Care CHIP, a child or teenager must be uninsured, have a familial income less than or equal to 200 percent of the FPL, and also be ineligible for Wyoming Medicaid.[13] Kid Care CHIP was established under Title XXI of the Social Security Act, and is also funded jointly by the state and federal governments (although with a higher federal match rate than for Wyoming Medicaid).

[11] Wyoming Department of Health, "Who is Eligible for Wyoming Medicaid," available at www.health.wyo.gov/Media.aspx?mediaId=7940.

[12] This amount varies by household size. According to data provided to us by WDH, current monthly incomes under this standard are $362 for a one-person household, $512 for a two-person household, $590 for a three-person household, and $659 for a four-person household.

[13] Wyoming Department of Health. About Kid Care CHIP, (2008). Available online: http://www.health.wyo.gov/healthcarefin/chip/about.html

Other health-related programs are administered and funded by WDH, some with and some without federal matching. Some of these programs serve individuals who will likely become eligible for Wyoming Medicaid starting in 2014; these overlapping programs are discussed in more detail later in this report.

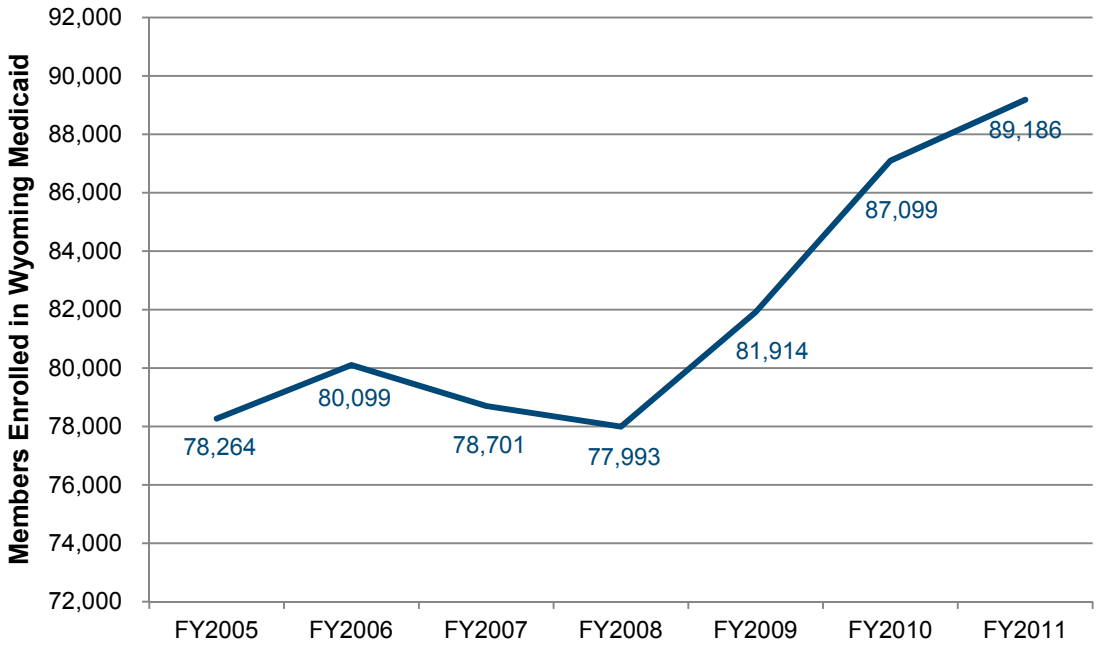
RETROSPECTIVE ANALYSIS OF ENROLLMENT AND COSTS

To form a reasonable baseline for our projections of enrollment and cost, we began by summarizing historical enrollment and cost trends for Wyoming Medicaid. This section provides an overview of our retrospective analysis of Wyoming Medicaid's enrollment and cost experience.

Medicaid enrollment trends

Overall enrollment in Wyoming Medicaid has risen 14 percent between FY 2005 and FY 2011. Figure 1 presents counts of unique members by fiscal year. To assess the influence of economic and social factors on enrollment trend, we obtained a variety of macroeconomic data including unemployment rates, gross domestic product (GDP), industrial revenue, inflation, household income, and population stratification by federal poverty levels. Medicaid enrollment is correlated with a number of economic factors, including unemployment, GDP, and per capita income.

Figure 1. Member Counts by Fiscal Year[14]



Children constitute the largest proportion of members, with 56,944 members enrolled in the Children eligibility category in FY 2011. While some programs have declined in membership, the majority have increased in size. Table 4 provides detailed member counts by eligibility program for each fiscal year.

[14] This figure displays the number of unique members enrolled in Wyoming Medicaid at some point during each fiscal year shown. It is very common for members to be enrolled only for part of a year. Therefore, the number of members enrolled *at any one point* in a fiscal year will be lower than the number enrolled at any one point during the year.

Table 4 – Summary Of Wyoming Medicaid Enrollment by Eligibility Program, FY 2005 to FY 2011

Eligibility Program	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Children	50,159	50,983	50,094	49,434	52,151	55,822	56,944
Family Care Adults	9,130	8,625	7,894	7,432	7,647	8,047	8,306
AB&D - SSI & SSI Related	6,221	6,308	6,305	6,492	6,808	6,885	7,030
Pregnant Women	6,143	6,555	6,460	6,260	6,127	6,201	5,970
AB&D - Home & Community Based Waivers	3,535	3,796	3,996	4,107	4,258	4,518	4,453
Medicare Savings Programs	2,205	3,090	3,283	3,322	3,566	3,954	4,367
AB&D - Institution	3,913	3,809	3,441	3,308	2,846	2,643	2,585
Special Groups	126	151	162	222	443	1,054	1,447
Non Citizens with Medical Emergencies	379	443	482	710	1,037	1,121	1,067
AB&D - Employed Individuals w/Disabilities	6	13	54	122	197	215	249
All Eligibility Programs[15]	**78,264**	**80,099**	**78,701**	**77,993**	**81,914**	**87,099**	**89,186**

Medicaid cost trends

We calculated costs paid per member per month (PMPM) for each eligibility program, by service category and incurred fiscal year. In order to align the results of this analysis with the current delivery of services and annual reporting, service categories were defined using the same methods employed by the State in its Wyoming Medicaid annual report.[16]

Between fiscal years 2005 and 2011, the overall PMPM cost increased 13.5 percent. Table 5 presents paid costs per member per month for each fiscal year by eligibility program. The highest PMPM costs were incurred by ABD members.

[15] Some members may be enrolled in more than one different eligibility program during the course of a year. For this reason, the "All Eligibility Programs" row is less than the sum of the rows above it.

[16] Wyoming Department of Health, Wyoming Medicaid Annual Report: State Fiscal Year 2011, pp. 118-27, available online: http://www.health.wyo.gov/healthcarefin/equalitycare/index.html

Table 5 – Summary of Per Member Per Month Paid Costs by Eligibility Program, FY 2005 to 2011

Eligibility Program	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Children	$187.15	$199.36	$209.87	$246.62	$274.21	$249.83	$238.56
Family Care Adults	$341.09	$336.66	$378.09	$413.69	$466.62	$462.78	$456.13
AB&D - SSI & SSI Related	$634.76	$573.38	$561.66	$622.18	$679.97	$716.86	$712.17
Pregnant Women	$701.10	$696.98	$790.66	$880.68	$920.81	$1,008.53	$1,026.30
AB&D - Home & Community Based Waivers	$3,133.24	$2,980.71	$3,019.28	$3,148.66	$3,274.48	$3,054.27	$3,222.72
Medicare Savings Programs	$35.52	$44.99	$57.22	$60.19	$67.39	$66.04	$70.50
AB&D - Institution	$3,013.42	$2,887.97	$3,316.94	$3,489.03	$4,036.25	$4,400.28	$4,439.35
Special Groups	$875.69	$975.88	$889.41	$836.78	$764.10	$339.51	$348.28
Non Citizens with Medical Emergencies	$398.06	$475.12	$380.47	$348.63	$282.03	$296.60	$238.25
AB&D - Employed Individuals w/Disabilities	$2,986.66	$2,360.17	$1,136.92	$1,680.86	$1,281.31	$1,438.24	$1,305.96
All Eligibility Programs[17]	**$528.13**	**$523.01**	**$556.13**	**$611.87**	**$642.18**	**$608.79**	**$599.63**

[17] The categories differ significantly in enrollment, as shown in Table 4. The averages shown in this row are weighted by enrollment (and thus do not equal the simple arithmetic average of the rows above).

ENROLLMENT PROJECTIONS FOR 2014 AND BEYOND

Our best estimate is that the ACA's reforms, if fully implemented, will result in an additional 28,200 members enrolling in Wyoming Medicaid by 2016. We also constructed high and low enrollment scenarios, assuming higher and lower rates of participation by eligible individuals. The high enrollment estimate is 44,500 expansion members by 2016. The low enrollment estimate is 16,800 expansion members by 2016. This section discusses the composition of these estimates, with a detailed breakdown shown below in Table 6. The figures in this paragraph are for the full ACA expansion population; if Wyoming elects not to expand Medicaid to the targeted ACA adult population, some of this growth would nonetheless occur due to the ACA's individual mandate and the requirement to cover children up to the 138% FPL income requirement.

Source of new members

In our modeling, the additional expected Wyoming Medicaid members can be classified as follows.

- A "woodwork" population that is already eligible for Medicaid but not currently enrolled (but who will enroll in 2014 due to the individual mandate under the ACA or increased awareness). This population is not affected by Wyoming's decision of whether to expand Medicaid; they are already eligible under current law.
- An expanded adult population (which would become eligible only if Wyoming chooses to expand Medicaid), composed of the following:
  - Adults who are currently uninsured and not eligible for Medicaid but who would become eligible starting in 2014 due to having an income below 138% of the federal poverty level.
  - Adults with private insurance prior to implementation of healthcare reform, but who are expected to lose or drop coverage in favor of Medicaid should the program be expanded and who would meet the 138% FPL income requirement.
  - Adults with household income slightly above the 138% threshold who lack group coverage and will deliberately reduce their income in order to qualify for Medicaid.
- A newly eligible child population, composed of the following:
  - Children ages 6-18 who are currently enrolled in Kid Care CHIP and who have household incomes under 138% FPL. These children would be transferred to the Medicaid program.
  - Children ages 6-18 who are currently uninsured but eligible for (but not enrolled in) Kid Care CHIP.
  - Children with private insurance prior to implementation of healthcare reform, but who are expected to lose or drop coverage in favor of Medicaid should the program be expanded and who would meet the 138% FPL income requirement.
  - Children with household income slightly above the 138% threshold who lack group coverage and will deliberately reduce their income in order to qualify for Medicaid.

We assume these newly enrolled members will most resemble existing members of the Children and Family Care Adult programs, with some adjustments made for differences in age/gender, health status, and other factors. Another

difference is the addition of a new eligibility program for single adults. The ACA's expansion of Medicaid is based on an income test. Those who are eligible due to disability or pregnancy, for example, are not directly affected by the ACA's expansion of Medicaid.

Model of Medicaid expansion

After reviewing Wyoming Medicaid's historical enrollment data, including comparison of enrollment trends to trends in several macroeconomic variables that are relevant to the State of Wyoming, we constructed a model of the health insurance marketplace in Wyoming. Our model projects the population counts in 2014, 2015, and 2016 for the following current health insurance market segments by income band:

- Uninsured
- Individually insured, on or off the Exchange
- Insured with employer-based coverage (small and large group, self-insured and fully insured)

There is uncertainty regarding how many people will become eligible for Wyoming Medicaid as a result of the ACA's reforms, and there is additional uncertainty regarding how many people will choose to enroll given the opportunity. The following subsections discuss the assumptions and methodologies underlying our estimates.

UNINSURED

Although there will be an individual mandate, we expect that some people who qualify for Wyoming Medicaid will not enroll and will remain uninsured. Evidence of this can be seen in today's marketplace where many people are already eligible for Medicaid but have chosen not to enroll. This "woodwork" population will, to some extent, "come out of the woodwork" due to the individual mandate, but it is unlikely to be 100% of those who are eligible. Among those newly eligible due to the higher FPL threshold for Medicaid eligibility, we similarly expect that some will simply not enroll.

INDIVIDUALLY INSURED

We expect some degree of "inertia" among low-income individuals who currently have private individual insurance; even though Wyoming Medicaid would be a lower-cost option, we expect that not all would choose to drop private coverage in favor of Wyoming Medicaid.

GROUP INSURED

We assume that during the initial years after healthcare reform takes effect, some employers who currently offer group coverage will elect to stop offering group coverage, leaving employees and their families to seek coverage on the individual Exchange or through Medicaid. We expect a greater propensity to do this among employers with employees in lower income tiers. Among members of employer plans that are terminated, we expect that most, though not all, will seek replacement coverage; those with incomes below 138% FPL who seek coverage would enroll in Wyoming Medicaid.

DELIBERATELY IMPOVERISHED

We understand that Senate Enrolled Act 93 (signed by the Governor on March 20, 2011), which authorizes this study, provides baseline assumptions for the percentage of the population with incomes below 200% FPL that would deliberately reduce income in order to qualify for Medicaid. The Act provides that different estimates may be used "based on expert opinion," and we have chosen to do this. The ACA provides significant subsidies for lower-income

individuals to purchase coverage through the Exchange; we expect that premium subsidy to be nearly 100% for most people with incomes up to 150% FPL, and not much below that for individuals with incomes up to 200% FPL. Cost sharing subsidies are also available for low income enrollees through the health insurance Exchange. We expect that few people would reduce income in order to qualify for Medicaid in the presence of these subsidies.

SENSITIVITY TESTING

We constructed our best estimate enrollment scenario based on our study of health insurance enrollment behavior from various public and private data sources, applying that research to develop each of the Medicaid take-up assumptions described above. As with any future projection, our best estimate is likely to vary from actual results. We therefore developed what we believe to be informative low-enrollment and high-enrollment scenarios by varying our take-up assumptions. With the exception of the "deliberately impoverished" population described in the previous paragraph, our high enrollment scenario reflects full participation (100% Medicaid take-up). While we do not believe it is likely that every person who could enroll will do so, this provides a good measure of how high Medicaid enrollment could go, in theory, as a result of the ACA. The low enrollment scenario is based on a series of reduced take-up rates; these should not be considered the lowest possible enrollment. The best estimate scenario is not (and should not be thought of as) an average of the low and high scenarios.

Table 6 below shows our estimates for enrollment in each of these scenarios, broken down by population segment. The counts in this table represent enrollment during calendar year 2016; the largest share of the full ACA expansion population will enroll in 2014, but under the assumptions of our modeling, it takes three years for the effect of the ACA's reforms to be fully manifested in Wyoming Medicaid's enrollment counts.

Table 6 – Summary of Projected Wyoming Medicaid Full ACA Expansion Population[18]

Population Segment, By Pre-2014 Insurance Status	Low Enrollment Scenario	Best Estimate Scenario	High Enrollment Scenario
Wyoming Medicaid Full ACA Expansion by 2016 (assuming full expansion)	16,800	28,200	44,500
Woodwork, adults and children (Not Optional)	700	3,700	10,800
Expansion Adults	11,500	17,600	22,900
Uninsured in 2013, not previously Medicaid-eligible, elects Medicaid	8,700	12,900	14,800
Private individual or group insurance	2,800	4,600	8,000
Near-poor, deliberately lowers income to qualify for Medicaid	0	100	200
Newly Eligible Children (Not Optional)	4,600	6,900	10,800
Private individual or group insurance	2,900	4,600	8,000
Near-poor, deliberately lowers income to qualify for Medicaid	<100	<100	100
Children ages 6-18 transferred from Kid Care CHIP to Medicaid	800	1,000	1,300
Already eligible for CHIP (but not enrolled) and newly enrolled in Medicaid in 2014	1,000	1,200	1,400

[18] Population estimates in this table are rounded to the nearest 100. Due to rounding, the grand total displayed is not always exactly equal to the sum of the rows below.

Impact on other Wyoming programs

We expect that some of the newly eligible members who will enroll in Wyoming Medicaid starting in 2014 will be people who would have otherwise been eligible for other state-funded programs. This would result in reduced enrollment and costs for those programs, offsetting some of the cost of Medicaid expansion to the state. Here, we provide a list of some of the programs that could be affected; the dollar amount shown after each program name is the program's proposed general fund appropriation for the 2013-14 biennium (for programs where detail is available in the budget).[19]

It should also be noted that some users of these programs likely are uninsured and have incomes between 138% and 400% FPL and would therefore be eligible for premium subsidies on the Exchange. While this is not a direct result of Medicaid expansion, it is another feature of the ACA that could lower the number of uninsured persons relying on these programs.

- **Prescription Drug Assistance Program (PDAP) ($4 million).** This program provides a prescription drug benefit for individuals not eligible for Medicaid, but with income below 100% FPL.[20] According to WDH data, approximately 6,400 people were eligible for coverage at some point in FY 2011. The PDAP is fully funded by the state, with no federal matching funds. WDH data show that the program cost approximately $1.66 million in FY 2011, and the 2013-14 biennium budget for the program is $3.9 million. Due to the current income threshold, we estimate that all currently covered members would be eligible for expanded Wyoming Medicaid starting in 2014.

- **Wyoming State Hospital ($76 million)**. This facility, located in Evanston, Wyoming, is a 98-bed psychiatric hospital. The hospital provides services to the indigent and is primarily funded by the state. During the 2011-12 biennium, the hospital had nearly 500 admissions and received more than $60 million from Wyoming's general fund. During 2011-12, the hospital generated only $1.4 million in revenue from all third party payers (including, but not limited, to Medicaid).[21] Medicaid expansion under the ACA could reduce the general fund outlay for Wyoming State Hospital; some persons currently served would become eligible for Wyoming Medicaid, which will (as discussed in the next section) receive considerable federal funding.

- **Children's Health Insurance Program ($11 million)**. This program (known within Wyoming as Kid Care CHIP), is a jointly funded (state and federal) program that provides health insurance to low-income children who do not qualify for Medicaid. The federal matching percentage is higher for Kid Care CHIP than for Wyoming Medicaid (currently 65%, compared to 50% for Wyoming Medicaid). Unlike Wyoming Medicaid, where the state directly reimburses providers on a fee-for-service basis, children enrolled in Kid Care CHIP receive coverage through private insurers (currently Blue Cross Blue Shield of Wyoming and Delta Dental), with the state paying the premium. Kid Care CHIP had 5,453 enrollees as of August 2011. The State has estimated that when the ACA takes effect, about 1,000 children enrolled in Kid Care CHIP will be transferred to Wyoming Medicaid due to

[19] State of Wyoming, 2013-2014 Biennium Budget Request: Department of Health (available at http://ai.state.wy.us/budget/pdf/13-14IndividualStateBudgetRequests/048.pdf).

[20] State of Wyoming, 2013-2014 Biennium Budget Request: Department of Health (available at http://ai.state.wy.us/budget/pdf/13-14IndividualStateBudgetRequests/048.pdf), p. 52.

[21] State of Wyoming, 2013-2014 Biennium Budget Request: Department of Health (available at http://ai.state.wy.us/budget/pdf/13-14IndividualStateBudgetRequests/048.pdf), p. 243.

Wyoming Medicaid's new eligibility requirements.[22] WDH expects the per member per month (PMPM) premium for Kid Care CHIP members to be $282.07 in FY 2014. This implies an annual reduction in total Kid Care CHIP expenses of approximately $3.4 million starting in calendar year 2014; about $1.2 million of that (35%) would have been paid by the State, while the rest would have been paid by the federal government. Under the ACA (as amended by the Reconciliation Act), the CHIP program is required to continue until 2019. The legislation provides for an additional federal matching rate of 23 percentage points on top of the existing 65% enhanced FMAP for CHIP beginning on October 1, 2015, and ending September 30, 2019. The additional 23 percentage points will increase the Wyoming CHIP FMAP to 88%. The Enhanced FMAP will decrease expenditures for Wyoming and increase expenditures for the federal share.

- **Wyoming breast and cervical cancer coverage**. Uninsured women with a personal income below 250 percent FPL are currently eligible for Wyoming Medicaid. Under Medicaid expansion, women with incomes up to 133% of the FPL will be eligible for Medicaid with the much higher federal matching percentage that accompanies Medicaid expansion under the ACA. Wyoming may choose to continue coverage for women with incomes between 138 and 250 percent FPL. We expect that membership for women with incomes above 138% FPL will decline due to opportunities to purchase heavily subsidized coverage on the Exchange. We expect a similar trend with tuberculosis patients currently eligible for Wyoming Medicaid, some of whom would be eligible for Medicaid coverage under the expanded Family Care program (income less than 138% of the FPL), and others with incomes exceeding 138% FPL choosing to purchase subsidized insurance on the Exchange.
- **Behavioral health outpatient services ($114 million)**. The state-funded behavioral health outpatient services (Behavioral Health Division) could serve fewer members with the expansion of Wyoming Medicaid under the ACA. Some, though not all, of this expense would be shifted to Wyoming Medicaid (with a federal match) because some current utilizers of Behavioral Health Division services would likely become Medicaid-eligible starting in 2014.
- **Wyoming Colorectal Cancer Screening Program (WCCSP).** This program, in place since 2007, provides colonoscopies to individuals over age 50 with incomes under 250% FPL. Many individuals currently served by this program would be eligible for Medicaid starting in 2014 and could obtain coverage for colonoscopies through Wyoming Medicaid. From the program's inception through the end of FY 2010, more than 1,700 people have been screened.[23] This is an average of over 800 screenings per year. Because some people served by this program would still not be eligible for expanded Medicaid after implementation of the ACA, the program would not be completely duplicative. We estimate that WCCSP expenditures could decrease by up to $600,000 due to Medicaid expansion.
- **Programs within the Wyoming Department of Health.** A variety of other, mostly smaller, programs could serve fewer members with the ACA Medicaid expansion. These include the children's marginal dental program, state-funded health coverage for foster care children not currently eligible for Wyoming Medicaid, and the Community

[22] State of Wyoming, 2013-2014 Biennium Budget Request: Department of Health (available at http://ai.state.wy.us/budget/pdf/13-14IndividualStateBudgetRequests/048.pdf), pp. 48-49.

[23] State of Wyoming, 2013-2014 Biennium Budget Request: Department of Health (available at http://ai.state.wy.us/budget/pdf/13-14IndividualStateBudgetRequests/048.pdf), p. 183.

and Public Health Division of the WDH. The Public Health Division of the Wyoming Health Department operates several programs, some of which would likely see a reduction in covered population with the expansion of Wyoming Medicaid. These include (dollar amounts are budgeted general fund appropriations for 2013-14) Public Health Nursing ($12 million), Immunization Program ($9 million), Maternal and Family Health ($4), and Oral Health Programs ($1 million). To the extent that some of the citizens served by these programs become eligible for Wyoming Medicaid due to its expansion under the ACA, Wyoming Medicaid would cover some of the services currently sought under these programs. The Wyoming Life Resource Center (WLRC), another program operated by the WDH, provides medical, residential, and other services for citizens with intellectual disabilities and acquired brain injuries, some of whom may become eligible for Wyoming Medicaid under the ACA expansion. Medicaid-covered medical services under this program could then be shifted to Wyoming Medicaid for those members, where federal funding would cover much of the cost. Finally, the Office of Rural Health, which coordinates care in rural areas, may see a decrease in funding needs if Medicaid coverage is expanded.

- **Reduction in uncompensated care.** Hospitals and other healthcare providers bear much of the burden of uncompensated care in Wyoming. Much of this cost is then shifted onto those who have private health insurance in the form of higher prices for healthcare services, resulting in higher health insurance premiums. Wyoming experiences this "hidden cost" in the form of higher state employee health insurance premiums. The White House estimated that the hidden cost of uncompensated care for Wyoming amounts to $4.5 million per year.[24] The expansion of Wyoming Medicaid would lead to a reduction in the number of uninsured and likewise reduce uncompensated care, which could in turn reduce Wyoming's expenditures on employee health insurance premiums.

[24] The Impact of Health Insurance Reform on State and Local Governments. Executive Office of the President, Council of Economic Advisors. September 15, 2009. (available at http://www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf), p.96

PROJECTED COST OF FULL ACA MEDICAID EXPANSION

After evaluating Wyoming Medicaid's historical claim experience and analyzing characteristics of the population segments described in the previous section, we developed estimates of the total cost of Medicaid expansion. If Wyoming expands Medicaid, our best estimate is that the State's share of additional Medicaid healthcare costs due to expansion will total $131 million for state fiscal years 2014-2020. There is **considerable uncertainty** around this estimate; accordingly, we constructed several scenarios to test the sensitivity of this estimate. These resulted in a projected cost range for full expansion of $53 million to $311 million over that same period. These estimates would be lower if Wyoming chooses not to expand Medicaid, but they would not be zero due to the existence of a woodwork population, as detailed below, and the requirement to cover children with incomes up to 138% of the FPL. This section provides further detail on these cost estimates.

Characteristics of expansion adult, newly eligible children, and woodwork populations

Before developing estimates for the cost of Medicaid expansion, it is important to evaluate the characteristics of the newly covered population. This population is expected to differ in a number of important ways from the population covered by Wyoming Medicaid today, even if we restrict our analysis to the Children and Family Care Adult groups which are most similar to the population that will be covered under the ACA expansion. Three key dimensions on which the expansion population will differ from today's Wyoming Medicaid population of Children and Family Care Adults are age/gender, health status, and presence of unmet medical needs. Each of these is discussed below.

AGE AND GENDER

The current Medicaid population is heavily weighted toward children and women. As seen in Table 6 above, the largest component of the full ACA expansion population is expected to be people currently uninsured (these individuals can belong to all three segments: woodwork, expansion adults, and newly eligible children). This uninsured population, based on Census data, is much more skewed towards adults and men than the current Medicaid population. The commercially insured population (the other source of expansion adult and newly eligible children members starting in 2014) has more children than the uninsured population, but still fewer than the Medicaid population. The adult population is roughly equally divided between men and women in the commercially insured population.

Past claim experience for Children and Family Care Adults cannot be extrapolated to project the post-2014 costs of the expansion or woodwork populations without adjusting for expected differences in the age/gender mix of the new populations.

HEALTH STATUS

We expect that the uninsured population (with incomes below 138% FPL) will have a similar mix of health status to the Children and Family Care adults enrolled today. The commercially insured population would likely have a better average health status, while the health status of the uninsured varies by population segment. For example, uninsured persons newly eligible for Medicaid are expected to have poorer health status than the "woodwork" population, which had always been eligible for Medicaid. This is because the "woodwork" population had always had the opportunity to enroll but chose not to, which in many cases could be attributable to a lack of serious health needs. The resulting significant variation in health status and expected costs among the different population segments was taken into account when developing baseline starting costs and adjustment factors. Prior to using historical Medicaid claim experience to project costs for the expansion adults, newly eligible children, and woodwork populations, we adjusted for these differences in health status.

Costs are expected to differ significantly within each segment due to age/gender mix and health status mix. Moreover, the different segments are expected to have different levels of unmet medical needs (which could elevate costs in the period shortly after first gaining Medicaid eligibility).

Therefore, we developed an assumed distribution of age/gender and health status for each population segment. The baseline distributions come from data retrieved from the Current Population Survey, which stratifies the population on age, gender, and health status (excellent, very good, good, fair, or poor), separately for the insured population and the uninsured population.

We used actuarial judgment to adjust the raw Current Population Survey distributions among the uninsured for differences we would expect to see among the various population segments. Specifically, we would expect that the "out of the woodwork" population would be healthier, on average, than the population of uninsured persons newly gaining eligibility for Medicaid. This is because the "out of the woodwork" population had the opportunity to enroll but chose not to do so, which in many cases could be attributable to a lack of serious health needs.

Table 7 presents the expected health status distribution by age/gender group for the previously uninsured persons in the adult expansion and newly eligible child populations. The parallel distributions for the other population sources vary only slightly from the distribution presented in this table.

Table 7 – Health Status Distribution by Age and Gender

AGE/GENDER	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
Newborns	40%	34%	24%	2%	0%
1 year old	44%	30%	22%	3%	1%
2 to 6 years old	44%	30%	21%	3%	2%
7 to 18 years old	40%	30%	25%	3%	2%
Males, 19-22	33%	31%	31%	4%	1%
Males, 23-24	27%	36%	32%	4%	1%
Males, 25-29	23%	32%	33%	9%	3%
Males, 30-34	22%	31%	34%	11%	2%
Males, 35-39	22%	28%	35%	12%	3%
Males, 40-44	20%	26%	38%	12%	4%
Males, 45-49	11%	27%	41%	17%	4%
Males, 50-54	17%	20%	36%	20%	7%
Males, 55-59	12%	17%	40%	21%	10%
Males, 60-64	10%	24%	33%	19%	14%
Females, 19-22	33%	32%	30%	4%	1%
Females, 23-24	25%	35%	32%	7%	1%
Females, 25-29	24%	32%	34%	9%	1%

Table 7 – Health Status Distribution by Age and Gender

AGE/GENDER	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
Females, 30-34	22%	28%	37%	10%	3%
Females, 35-39	18%	30%	38%	11%	3%
Females, 40-44	16%	24%	39%	15%	6%
Females, 45-49	15%	24%	35%	17%	9%
Females, 50-54	11%	19%	36%	23%	11%
Females, 55-59	9%	16%	40%	23%	12%
Females, 60-64	8%	15%	40%	23%	14%

UNMET NEEDS

Individuals covered by Medicaid (or any type of private health insurance) have had access to care for the period of time they have been covered. The uninsured may not have been able to access care for some period of time due to inability to pay. Therefore, members of the full ACA expansion population are expected to have unmet medical needs not found in the currently enrolled Medicaid population. As a result, beginning costs are expected to be higher for newly enrolled members. When projecting future costs, we adjusted the costs of formerly uninsured individuals for the presence of these unmet needs that result in elevated cost levels in the period shortly after gaining coverage.

Cost model

We constructed a model to project per member per month (PMPM) costs for each segment of the population, stratified by population segment (defined above in Table 6), age band, gender, and health status.

While there are many areas of uncertainty in projecting future healthcare costs, one of the most important is the PMPM trend rate. Absent changes to the covered benefits, the most important components of PMPM trend are the rate of growth in healthcare unit costs and utilization rates. Change in unit costs can be driven by many factors, including fee schedules, practice patterns (shifts may occur whereby more expensive interventions tend to be substituted for less expensive ones, or vice versa), development of new technologies or drugs, and loss of patent protection for existing drugs. Utilization rates may change due to practice patterns, changes in disease prevalence (due to lifestyle, epidemics of infectious conditions, increased awareness or detection, and other causes), changes in the supply of services (such as more or fewer doctors, hospitals, or radiology equipment being available), and duration of coverage (a population that recently gained insurance coverage is more likely to have unmet medical needs potentially requiring expensive interventions). All these factors affect average PMPM trend; growth in aggregate spending is driven both by PMPM cost as well as by the number of enrollees.

Based on our review of the historical experience reports discussed above and our actuarial judgment, our best estimate of the long-term annual PMPM trend rate for 2011 to 2020 is 4%. This rate could, in practice, be affected by many factors, including but not limited to the ones discussed in the previous paragraph. Because of these and other sources of uncertainty, we constructed two alternate scenarios, using trend rates of 2% and 6%. There is no guarantee that PMPM costs will be confined to that range, but we believe that showing alternate scenarios presents a more realistic view of the range of likely outcomes over the period of these projections.

We do not explicitly model changes in provider fee schedules, but these are implicitly modeled in the range of trend rates described above. Wyoming Medicaid's reimbursement rates have been fairly stable in recent years;[25] to the extent that rates increase in the future, this would be equivalent to a higher trend rate (and vice versa).

Medicaid costs: State and Federal

At present, Wyoming's Medicaid expenses are shared 50/50 between the State and Federal governments. The federal share of Medicaid spending varies by state and is inversely related to each state's per capita income, within certain limits. The percentage may be adjusted by the federal government (as happened temporarily, for example, after passage of the American Recovery and Reinvestment Act of 2009), but we have assumed that the federal match for the current Medicaid population coverage in Wyoming will remain 50% through our projection period. We have also assumed that the enhanced FMAP applicable to Kid Care CHIP (or to children newly enrolled in Medicaid who were previously eligible for Kid Care CHIP) would remain at 65%, except for the three-year period where it is subject to the 23 percentage point increase (as discussed above).

However, for the adult expansion population, the ACA provides for a significantly higher federal match rate. That rate begins at 100% in 2014 and declines to 90% by 2020. This higher match applies to expansion adults who are newly eligible under the ACA; it would not apply to members already eligible, including the "woodwork" population segment. It would also not apply to newly eligible children. Some, but not all, members who currently have group or individual private insurance would be subject to the higher federal match rate; this is the reason that the "Expansion Adult" state share is not zero in the first three years (when FMAP is 100%). It is our understanding that children who currently are eligible for CHIP (but not Medicaid), regardless of whether they are currently enrolled in CHIP, would receive the CHIP FMAP starting in 2014 rather than the Medicaid FMAP that applies to children.

Tables 8, 9, and 10 below present our estimates of state and federal spending for the full ACA expansion population for FY 2014 to FY 2020 in our best estimate scenario, low enrollment scenario, and high enrollment, scenario, respectively. In all three tables, we used our best estimate for future cost and utilization trend. Appendix A contains parallel tables for our high and low trend scenarios.

[25] For a description of recent changes to reimbursement rates, see *Wyoming Medicaid Annual Report: State Fiscal Year 2011*, page 136.

Table 8 – Best Estimate Projected Cost For Full ACA Expansion Population, FY 2014 to FY 2020 ($MM)								
	2014	2015	2016	2017	2018	2019	2020	Total
State share	**$6.8**	**$14.1**	**$14.7**	**$18.0**	**$22.5**	**$25.1**	**$30.0**	**$131.2**
Woodwork Population (Not Optional)	$3.9	$7.8	$7.7	$7.9	$8.3	$8.7	$9.1	$53.3
Expansion Adults	$0.3	$0.7	$0.9	$4.0	$7.8	$9.4	$12.6	$35.7
Newly Eligible Children (Not Optional)	$2.6	$5.7	$6.1	$6.1	$6.4	$7.0	$8.4	$42.2
Federal share	**$57.5**	**$119.6**	**$129.1**	**$134.3**	**$137.0**	**$142.0**	**$144.9**	**$864.4**
Woodwork Population (Not Optional)	$3.9	$7.8	$7.7	$7.9	$8.3	$8.7	$9.1	$53.3
Expansion Adults	$50.0	$103.6	$110.8	$114.1	$115.9	$120.1	$123.1	$737.8
Newly Eligible Children (Not Optional)	$3.5	$8.2	$10.6	$12.3	$12.8	$13.2	$12.7	$73.4
Total	**$64.3**	**$133.8**	**$143.8**	**$152.3**	**$159.5**	**$167.0**	**$174.9**	**$995.7**
Woodwork Population (Not Optional)	$7.9	$15.6	$15.4	$15.8	$16.5	$17.3	$18.1	$106.6
Expansion Adults	$50.3	$104.3	$111.7	$118.1	$123.7	$129.6	$135.7	$773.5
Newly Eligible Children (Not Optional)	$6.1	$13.9	$16.7	$18.4	$19.2	$20.2	$21.1	$115.6

Table 9 – Low Enrollment Projected Cost for Full ACA Expansion Population, FY 2014 to FY 2020 ($MM)								
	2014	2015	2016	2017	2018	2019	2020	Total
State share	**$2.6**	**$5.7**	**$6.0**	**$7.9**	**$10.7**	**$12.2**	**$15.3**	**$60.4**
Woodwork Population (Not Optional)	$0.7	$1.4	$1.4	$1.4	$1.5	$1.6	$1.6	$9.7
Expansion Adults	$0.2	$0.4	$0.6	$2.6	$5.0	$6.1	$8.2	$23.1
Newly Eligible Children (Not Optional)	$1.7	$3.8	$4.0	$3.9	$4.1	$4.5	$5.5	$27.6
Federal share	**$36.1**	**$75.1**	**$81.1**	**$84.4**	**$86.0**	**$89.1**	**$90.7**	**$542.5**
Woodwork Population (Not Optional)	$0.7	$1.4	$1.4	$1.4	$1.5	$1.6	$1.6	$9.7
Expansion Adults	$32.9	$67.9	$72.3	$74.4	$75.5	$78.3	$80.2	$481.6
Newly Eligible Children (Not Optional)	$2.5	$5.7	$7.4	$8.6	$9.0	$9.2	$8.8	$51.2
Total	**$38.8**	**$80.8**	**$87.1**	**$92.3**	**$96.7**	**$101.2**	**$106.0**	**$602.9**
Woodwork Population (Not Optional)	$1.4	$2.8	$2.8	$2.9	$3.0	$3.1	$3.3	$19.4
Expansion Adults	$33.1	$68.4	$72.9	$77.0	$80.6	$84.4	$88.4	$504.7
Newly Eligible Children (Not Optional)	$4.3	$9.6	$11.4	$12.5	$13.1	$13.7	$14.3	$78.9

Table 10 – High Enrollment Projected Cost for Full ACA Expansion Population, FY 2014 to FY 2020 ($MM)								
	2014	2015	2016	2017	2018	2019	2020	Total
State share	**$16.5**	**$33.5**	**$34.2**	**$39.0**	**$45.7**	**$50.0**	**$57.4**	**$276.2**
Woodwork Population (Not Optional)	$11.5	$22.6	$22.4	$23.0	$24.1	$25.2	$26.4	$155.1
Expansion Adults	$0.6	$1.3	$1.6	$5.8	$10.9	$13.2	$17.4	$51.0
Newly Eligible Children (Not Optional)	$4.4	$9.5	$10.2	$10.2	$10.7	$11.6	$13.5	$70.2
Federal share	**$84.6**	**$175.4**	**$188.3**	**$195.8**	**$200.2**	**$207.6**	**$212.4**	**$1,264.3**
Woodwork Population (Not Optional)	$11.5	$22.6	$22.4	$23.0	$24.1	$25.2	$26.4	$155.1
Expansion Adults	$67.4	$139.9	$149.9	$154.5	$157.0	$162.7	$166.7	$998.0
Newly Eligible Children (Not Optional)	$5.7	$12.9	$16.1	$18.3	$19.2	$19.7	$19.3	$111.2
Total	**$101.1**	**$208.9**	**$222.5**	**$234.8**	**$245.9**	**$257.6**	**$269.7**	**$1,540.5**
Woodwork Population (Not Optional)	$23.0	$45.3	$44.7	$45.9	$48.1	$50.4	$52.8	$310.2
Expansion Adults	$68.0	$141.2	$151.5	$160.3	$167.9	$175.9	$184.2	$1,049.0
Newly Eligible Children (Not Optional)	$10.1	$22.4	$26.3	$28.6	$29.9	$31.3	$32.8	$181.4

Administrative costs

Tables 8–10 above provide estimates of healthcare costs only; these do not include administrative expenses. In our experience, administrative costs for a Medicaid program typically fall between 3.5% and 6.0% of healthcare costs. Expansion of Medicaid likely would cause an increase in administrative costs due to growth in membership and associated costs of managing enrollment, processing claims, and performing other overhead functions. Because these populations will be adults and children (who typically have lower claim costs than ABD members), our best estimate for administrative costs is 4% of the amounts shown in Table 8 above. For our best estimate scenario, this would total approximately the following amounts from FY 2014 to FY 2020:

- $4.3 million for the woodwork population
- $30.9 million for the adult expansion population
- $4.6 million for the newly eligible child population

These are total administrative costs; states generally receive an FMAP of 50% for administrative costs,[26] meaning that half of these amounts would be covered by the federal government.

Cost offsets from other programs

The previous section, under "Impact on other Wyoming programs," discussed several other WDH programs that might become unnecessary with the expansion of Wyoming Medicaid, might serve fewer members if some of their current

[26] Congressional Research Service, "Medicaid: The Federal Medical Assistance Percentage (FMAP)," 25 March 2010, p. 1.

members obtain Medicaid coverage, or might replace state general fund reimbursement for some of their services with Medicaid reimbursement (that includes federal matching). From a state budgetary perspective, the cost estimates for Medicaid expansion in Tables 8–10 should be read in light of the possible cost offsets from these other programs discussed in the previous section.

Other financial impacts of the Supreme Court decision on June 28, 2012

While the full implications of the Supreme Court decision are still unfolding, there are a few outstanding issues and questions that may be of particular interest to states. The Supreme Court decision gives states the option not to participate in Medicaid expansion for adults. If states choose not to expand Medicaid coverage to the targeted adults, there are many questions about how this may affect the population that would have been Medicaid-eligible through the expanded coverage. The following provides a series of Medicaid-related questions, although it is not an exhaustive list.

- If a state does not participate in the Medicaid expansion, will adults below the 133% federal poverty level (FPL) threshold qualify for premium tax credits and cost sharing subsidies? Under the ACA as it currently stands, families with incomes of less than 100% of the FPL are not "applicable taxpayers" eligible for premium subsidies. An applicable taxpayer is defined by the ACA as being between 100% and 400% of the FPL. If Medicaid is not expanded, some families are currently in a coverage gap regarding financial aid to obtain medical coverage.
- It is unclear if states can expand Medicaid coverage for adults to another FPL level (less than 133%) and still receive the enhanced federal matching. Expansion of Medicaid might be a "yes or no" decision to be able to receive the enhanced federal match rate. Otherwise, coverage to a lower FPL threshold may require state participation at the standard match rate, which is currently 50% in Wyoming.

It is now up to the Wyoming legislature to pass legislation to expand adult Medicaid eligibility. The timing could create challenges for the commercial health insurance market in Wyoming given that the legislature does not meet again until January 8, 2013, leaving a very short time period for commercial insurers in Wyoming to understand the nature of their potential market and to develop and price their Exchange products accordingly (rates must be filed by July 2013). Further impacts in the commercial market may be felt in that opting out of expanded adult Medicaid coverage may expose Wyoming employers with over 50 employees to additional affordability penalties if their low income employees no longer qualify for Medicaid coverage.

This outlines only a few considerations that are specific to Wyoming Medicaid and the Supreme Court decision. There are many other aspects associated with the ACA and Medicaid expansion. Other considerations, which are not covered in our analysis, include but are not limited to:

- Impact to health care providers including hospitals that may experience a reduction in Medicare reimbursement as outlined under ACA;
- Impact to state and local tax revenues;
- Impact to uncompensated care and bad debt for health care providers; and
- Cost shifting between Medicaid, Medicare and commercial health insurance carriers.

Impact of other ACA provisions

Aside from the expansion of eligibility, the ACA contains a number of other provisions that could affect Medicaid costs. This section describes the impact of these provisions.

- **Foster Care**. The ACA mandates that the state extend Medicaid coverage up to age 26 for foster children who have aged out of the foster care system effective in 2014. We anticipate that the majority of individuals aging out of foster care in the state will already be eligible for expanded adult Medicaid based on income, and therefore this population does not significantly impact base projections. A study published by the University of Chicago reports there are high rates of unemployment among youth aging out of foster care, and that the average annual wages are well below the poverty threshold for an individual.[27] While there will be some individuals aging out of foster care that have incomes exceeding 138% FPL that do not have employer sponsored insurance, we anticipate that this number and the corresponding cost impact will be small.
- **Reductions in DSH allotments.** The federal government provides funding to hospitals treating indigent patients with a program called Disproportionate Share Hospital (DSH). This funding is concentrated among large hospitals in urban areas and teaching hospitals. Only hospitals with a Medicaid use rate of at least 1 percent can receive DSH payments. DSH payments to states are calculated based on a statutory federal formula. Wyoming's DSH payment is calculated based on Medicaid payments, cost of uncompensated care, and rates of self-pay. DSH funding will be reduced starting in 2014 based on characteristics of each state.[28] This reduction is to be distributed such that the largest reductions are for states with the lowest percentage of uninsured, and requires smaller reductions in low-DSH states. Wyoming is a low DSH state, meaning that between 0% and 3% of Medicaid spending is directed to DSH expenditures. On a per capita basis, Wyoming has the lowest DSH payments in the country. In 2011, the per capita DSH payments in Wyoming were approximately $0.42, compared with a national average of nearly $37 per person. The next lowest state, Utah, had a per-person DSH payment of nearly $7 per person.[29] While DSH payment are scheduled to be reduced significantly by 2020, we anticipate that Wyoming's extremely low DSH payment will be reduced very little, if at all.
- **Pharmacy rebates**. The ACA increased rebate percentages for covered outpatient drugs provided to Medicaid patients in 2010, and all additional costs accrued 100% to the Federal government. Based on instructions regarding the Pharmacy Rebate offset from HHS to state Medicaid agencies dated September 28, 2010, we estimate that there has been no material cost impact to the state.
- **Provider Reimbursement**. The ACA requires an increase in the Medicaid physician fee schedule for primary services. The federal government will fund an increase in some fees paid to primary care physicians equal to 100% of Medicare in 2013 and 2014 after which point no additional funding will be available.[30] Wyoming has

[27] Employment Outcomes for Youth Aging out of Foster Care. George et. al. University of Chicago Chapin Hall Center for Children. (http://aspe.hhs.gov/hsp/fostercare-agingout02/)

[28] ACA Section 1203.

[29] Kaiser Family Foundation, Federal Medicaid Disproportionate Share Hospital (DSH) Allotments, available at http://www.statehealthfacts.org/comparetable.jsp?ind=185&cat=4 (retrieved July 2, 2012).

[30] Reconciliation Act, Section 1202.

historically had high Medicaid physician reimbursement rates (as compared to other states – and to Medicare) so this supplemental provider reimbursement may have no impact.[31]

Cost projections for Wyoming Medicaid as it exists today

We have also provided estimates for the future costs of the Medicaid program as it exists today. For this, we assumed a baseline level of costs consistent with those in the historical experience reports discussed above and applied the same PMPM trend rates noted above. We also assumed modest membership growth consistent with recent membership growth experience.

Tables 11, 12, and 13 provide our cost projections for the existing Medicaid program (assuming no ACA impact) based on our best estimate, low estimate, and high estimate trends, respectively. These tables present the *total healthcare claim cost*. Because, as noted above, the federal match rate for Wyoming is 50%, only half this amount would come out of the state sources of funds. Administrative costs are not included in these three tables.

[31] Stephen Zuckerman, Aimee F. Williams and Karen E. Stockley. Trends in Medicaid Physician Fees, 2003 – 2008. Health Affairs, 28 no. 3 (2009): w510-w519. (published online April 28, 2009; 10.1377/hlthaff.28.3.w510)

Table 11 – Best estimate projected cost for current Medicaid programs, FY 2014 to FY 2020 ($MM)								
Eligibility Program	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Children	$149.6	$157.1	$165.0	$173.3	$182.1	$191.2	$200.9	$1,219.2
Family Care Adults	$35.1	$37.5	$40.2	$43.0	$46.1	$49.3	$52.8	$304.0
AB&D - SSI & SSI Related	$59.7	$63.3	$67.2	$71.3	$75.6	$80.2	$85.1	$502.3
Pregnant Women	$44.2	$47.8	$51.6	$55.7	$60.2	$65.0	$70.2	$394.6
AB&D - Home & Community Based Waivers	$173.0	$180.0	$187.3	$194.9	$202.7	$210.9	$219.5	$1,368.4
Medicare Savings Programs	$3.7	$4.0	$4.4	$4.7	$5.1	$5.5	$6.0	$33.4
AB&D - Institution	$121.1	$131.0	$141.6	$153.1	$165.5	$179.0	$193.5	$1,084.7
Special Groups	$4.4	$4.6	$4.9	$5.2	$5.5	$5.9	$6.2	$36.7
Non Citizens with Medical Emergencies	$2.3	$2.4	$2.6	$2.7	$2.9	$3.1	$3.2	$19.1
AB&D - Employed Individuals w/Disabilities	$3.4	$3.6	$3.9	$4.1	$4.3	$4.6	$4.9	$28.9
Total	**$596.5**	**$631.4**	**$668.6**	**$708.0**	**$750.0**	**$794.7**	**$842.2**	**$4,991.4**

Table 12 – Low trend estimate projected cost for current Medicaid programs, FY 2014 to FY 2020 ($MM)								
Eligibility Program	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Children	$141.1	$145.4	$149.7	$154.3	$158.9	$163.7	$168.7	$1,081.8
Family Care Adults	$32.2	$33.5	$34.8	$36.2	$37.7	$39.2	$40.8	$254.3
AB&D - SSI & SSI Related	$56.3	$58.6	$61.0	$63.4	$66.0	$68.7	$71.4	$445.4
Pregnant Women	$39.5	$41.1	$42.7	$44.4	$46.2	$48.0	$50.0	$311.9
AB&D - Home & Community Based Waivers	$168.0	$173.1	$178.3	$183.7	$189.2	$194.9	$200.8	$1,288.1
Medicare Savings Programs	$3.4	$3.6	$3.8	$4.0	$4.2	$4.4	$4.6	$27.9
AB&D - Institution	$111.1	$116.8	$122.7	$128.9	$135.4	$142.2	$149.4	$906.5
Special Groups	$4.1	$4.3	$4.4	$4.6	$4.8	$5.0	$5.2	$32.5
Non Citizens with Medical Emergencies	$2.1	$2.2	$2.3	$2.4	$2.5	$2.6	$2.7	$17.0
AB&D - Employed Individuals w/Disabilities	$3.2	$3.4	$3.5	$3.6	$3.8	$3.9	$4.1	$25.6
Total	**$561.1**	**$581.8**	**$603.3**	**$625.6**	**$648.7**	**$672.8**	**$697.8**	**$4,391.0**

Table 13 – High trend estimate projected cost for current Medicaid programs, FY 2014 to FY 2020 ($MM)								
Eligibility Program	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Children	$158.4	$169.5	$181.5	$194.3	$208.0	$222.7	$238.5	$1,372.9
Family Care Adults	$38.1	$42.0	$46.2	$50.9	$56.0	$61.7	$67.9	$362.7
AB&D - SSI & SSI Related	$63.2	$68.3	$73.9	$79.9	$86.4	$93.4	$101.0	$566.1
Pregnant Women	$49.3	$55.2	$61.9	$69.3	$77.6	$86.9	$97.4	$497.6
AB&D - Home & Community Based Waivers	$178.2	$187.2	$196.7	$206.6	$217.1	$228.1	$239.6	$1,453.4
Medicare Savings Programs	$4.1	$4.5	$5.0	$5.6	$6.2	$6.9	$7.7	$39.9
AB&D - Institution	$131.7	$146.4	$162.8	$181.0	$201.2	$223.7	$248.7	$1,295.6
Special Groups	$4.6	$5.0	$5.4	$5.8	$6.3	$6.8	$7.4	$41.3
Non Citizens with Medical Emergencies	$2.4	$2.6	$2.8	$3.0	$3.3	$3.6	$3.8	$21.6
AB&D - Employed Individuals w/Disabilities	$3.6	$3.9	$4.3	$4.6	$5.0	$5.4	$5.8	$32.6
Total	**$633.6**	**$684.8**	**$740.4**	**$801.0**	**$867.1**	**$939.1**	**$1,017.7**	**$5,683.7**

CAVEATS AND LIMITATIONS

In developing these estimates, we relied upon a number of public and non-public data sources. Public data sources include:

- The Current Population Survey (published by the US Census Bureau)
- Data and research from Kaiser Family Foundation
- Medicaid Statistical Information System
- Milliman Medical Index
- Inflation (CPI-U) historical data from the Bureau of Labor Statistics
- Other sources cited in footnotes throughout this report.

WDH provided us with detailed claim and enrollment data covering calendar years 2004 to 2011. We also relied upon discussions with personnel at WDH to better understand the WDH data. We have not audited any of these data sources, although we did review them all for reasonability and consistency. To the extent that these data sources contain inaccuracies, so may our analysis.

We have prepared this report based on the language of the ACA and regulations and guidance issued through the date of the report; we have not accounted for possible changes to the ACA as a result of the United States Supreme Court's June 28, 2012, decision regarding the constitutionality of the ACA. In this ruling, the Supreme Court held that the federal government may not withhold funding for the currently existing Medicaid program solely because a state does not comply with the ACA's expansion of Medicaid to the targeted adult population. The purpose of this report is to project enrollment and costs if Wyoming does expand Medicaid as outlined in the ACA. We make no recommendation as to whether Wyoming should or should not avail itself of the option apparently provided by the Supreme Court's June 28, 2012, decision.

The retrospective analyses contained in this report are summaries of historical data and should not be used to project future enrollment or claim experience without significant judgment and caution. We have used methods we believe to be reasonable to produce these retrospective analyses (such as methods to define service categories and enrollment categories), but other methods could also be valid and could produce different results.

The projections of future enrollment and future costs in this report are based on analysis of historical data and on actuarial judgment. We have presented ranges and sensitivity tests for our results because it is unlikely that actual enrollment or costs will exactly match our best estimates due to the inherent uncertainty of projecting medical costs, population growth rates, and human behavior. While we believe our ranges represent reasonable expectations, they should not be construed as the minimum and maximum values that could possibly occur.

We have prepared this report for WDH pursuant to Request for Proposal 0066-V, and we understand that this report was authorized under Senate Enrolled Act 93 from the sixty-first legislature of the State of Wyoming, 2011 general session. This report is intended to provide our best estimate (with reasonable sensitivity testing) for future enrollment and costs attributable to Medicaid expansion under the ACA. Milliman does not advocate for or against any action (including the passage or defeat of any legislation) based on our analysis. We anticipate that WDH will wish to make this report publicly available. Milliman does not intend to create a legal duty to any other party.

APPENDIX A: COST PROJECTION SENSITIVITY TESTS

As described in the report, we tested the sensitivity of our cost assumptions by varying the expected trend factor up and down. This is done to account for the uncertainty inherent in cost projections. While every assumption is subject to uncertainty, trend is a convenient parameter on which to conduct sensitivity tests because conceptually, any variation in the remaining assumptions could be thought of as an increase or decrease in the aggregate trend rate.

Table A1 – Projected Cost of the Full ACA Expansion Population, FY 2014 to FY 2020 ($MM)
Best Estimate Enrollment Assumptions
Best Estimate Trend Assumption

	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	$50.3	$104.3	$111.7	$118.1	$123.7	$129.6	$135.7	$773.5
State share	$0.3	$0.7	$0.9	$4.0	$7.8	$9.4	$12.6	$35.7
Federal share	$50.0	$103.6	$110.8	$114.1	$115.9	$120.1	$123.1	$737.8
Newly Eligible Children	$6.1	$13.9	$16.7	$18.4	$19.2	$20.2	$21.1	$115.6
State share	$2.6	$5.7	$6.1	$6.1	$6.4	$7.0	$8.4	$42.2
Federal share	$3.5	$8.2	$10.6	$12.3	$12.8	$13.2	$12.7	$73.4
Woodwork (Adults and Children)	$7.9	$15.6	$15.4	$15.8	$16.5	$17.3	$18.1	$106.6
State share	$3.9	$7.8	$7.7	$7.9	$8.3	$8.7	$9.1	$53.3
Federal share	$3.9	$7.8	$7.7	$7.9	$8.3	$8.7	$9.1	$53.3

Table A2 – Projected Cost of Full ACA Expansion Population, FY 2014 to FY 2020 ($MM) Best Estimate Enrollment Assumptions Low Estimate Trend Assumption								
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Expansion Adults	**$47.5**	**$97.5**	**$102.3**	**$106.1**	**$109.0**	**$112.0**	**$115.0**	**$689.5**
State share	$0.3	$0.6	$0.8	$3.6	$6.9	$8.1	$10.6	$31.0
Federal share	$47.2	$96.8	$101.5	$102.6	$102.2	$103.8	$104.4	$658.5
Newly Eligible Children	**$5.8**	**$12.9**	**$15.3**	**$16.5**	**$17.0**	**$17.4**	**$17.9**	**$102.8**
State share	$2.4	$5.3	$5.6	$5.5	$5.6	$6.0	$7.1	$37.6
Federal share	$3.3	$7.6	$9.7	$11.0	$11.3	$11.4	$10.8	$65.2
Woodwork (Adults and Children)	**$7.5**	**$14.5**	**$14.1**	**$14.2**	**$14.6**	**$15.0**	**$15.4**	**$95.2**
State share	$3.7	$7.3	$7.0	$7.1	$7.3	$7.5	$7.7	$47.6
Federal share	$3.7	$7.3	$7.0	$7.1	$7.3	$7.5	$7.7	$47.6

Table A3 – Projected Cost of Expansion Population, FY 2014 to FY 2020 ($MM) Best Estimate Enrollment Assumptions High Estimate Trend Assumption								
	2014	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Total**
Expansion Adults	**$53.3**	**$111.6**	**$121.7**	**$131.2**	**$140.1**	**$149.5**	**$159.6**	**$867.0**
State share	$0.3	$0.7	$1.0	$4.5	$8.8	$10.9	$14.8	$41.1
Federal share	$53.0	$110.8	$120.7	$126.7	$131.2	$138.6	$144.8	$825.9
Newly Eligible Children	**$6.5**	**$14.8**	**$18.2**	**$20.4**	**$21.8**	**$23.3**	**$24.8**	**$129.8**
State share	$2.7	$6.1	$6.7	$6.8	$7.3	$8.0	$9.9	$47.4
Federal share	$3.8	$8.8	$11.6	$13.6	$14.5	$15.2	$15.0	$82.4
Woodwork (Adults and Children)	**$8.4**	**$16.6**	**$16.8**	**$17.5**	**$18.7**	**$20.0**	**$21.3**	**$119.3**
State share	$4.2	$8.3	$8.4	$8.8	$9.4	$10.0	$10.7	$59.7
Federal share	$4.2	$8.3	$8.4	$8.8	$9.4	$10.0	$10.7	$59.7

Table A4 – Projected Cost of Full ACA Expansion Population, FY 2014 to FY 2020 ($MM) Low Estimate Enrollment Assumptions Best Estimate Trend Assumption								
	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	**$33.1**	**$68.4**	**$72.9**	**$77.0**	**$80.6**	**$84.4**	**$88.4**	**$504.7**
State share	$0.2	$0.4	$0.6	$2.6	$5.0	$6.1	$8.2	$23.1
Federal share	$32.9	$67.9	$72.3	$74.4	$75.5	$78.3	$80.2	$481.6
Newly Eligible Children	**$4.3**	**$9.6**	**$11.4**	**$12.5**	**$13.1**	**$13.7**	**$14.3**	**$78.9**
State share	$1.7	$3.8	$4.0	$3.9	$4.1	$4.5	$5.5	$27.6
Federal share	$2.5	$5.7	$7.4	$8.6	$9.0	$9.2	$8.8	$51.2
Woodwork (Adults and Children)	**$1.4**	**$2.8**	**$2.8**	**$2.9**	**$3.0**	**$3.1**	**$3.3**	**$19.4**
State share	$0.7	$1.4	$1.4	$1.4	$1.5	$1.6	$1.6	$9.7
Federal share	$0.7	$1.4	$1.4	$1.4	$1.5	$1.6	$1.6	$9.7

Table A5 – Projected Cost of Expansion Population, FY 2014 to FY 2020 ($MM) Low Estimate Enrollment Assumptions Low Estimate Trend Assumption								
	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	**$31.2**	**$63.9**	**$66.8**	**$69.1**	**$71.0**	**$73.0**	**$74.9**	**$449.9**
State share	$0.2	$0.4	$0.5	$2.3	$4.4	$5.3	$6.9	$20.0
Federal share	$31.0	$63.5	$66.2	$66.8	$66.6	$67.7	$68.0	$429.9
Newly Eligible Children	**$4.0**	**$8.9**	**$10.5**	**$11.2**	**$11.5**	**$11.8**	**$12.2**	**$70.2**
State share	$1.6	$3.6	$3.7	$3.5	$3.6	$3.9	$4.7	$24.6
Federal share	$2.4	$5.4	$6.8	$7.7	$7.9	$8.0	$7.5	$45.6
Woodwork (Adults and Children)	**$1.4**	**$2.6**	**$2.6**	**$2.6**	**$2.6**	**$2.7**	**$2.8**	**$17.3**
State share	$0.7	$1.3	$1.3	$1.3	$1.3	$1.4	$1.4	$8.7
Federal share	$0.7	$1.3	$1.3	$1.3	$1.3	$1.4	$1.4	$8.7

Table A6 – Projected Cost of Full ACA Expansion Population, FY 2014 to FY 2020 ($MM) Low Estimate Enrollment Assumptions High Estimate Trend Assumption								
	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	**$35.0**	**$73.1**	**$79.4**	**$85.5**	**$91.2**	**$97.4**	**$104.0**	**$565.6**
State share	$0.2	$0.5	$0.6	$2.9	$5.7	$7.1	$9.6	$26.5
Federal share	$34.8	$72.7	$78.8	$82.6	$85.5	$90.3	$94.3	$539.1
Newly Eligible Children	**$4.5**	**$10.2**	**$12.4**	**$13.9**	**$14.8**	**$15.8**	**$16.9**	**$88.6**
State share	$1.9	$4.1	$4.4	$4.4	$4.6	$5.2	$6.5	$31.0
Federal share	$2.7	$6.2	$8.1	$9.5	$10.2	$10.6	$10.4	$57.5
Woodwork (Adults and Children)	**$1.5**	**$3.0**	**$3.0**	**$3.2**	**$3.4**	**$3.6**	**$3.9**	**$21.7**
State share	$0.8	$1.5	$1.5	$1.6	$1.7	$1.8	$1.9	$10.8
Federal share	$0.8	$1.5	$1.5	$1.6	$1.7	$1.8	$1.9	$10.8

Table A7 – Projected Cost of Expansion Population, FY 2014 to FY 2020 ($MM) High Estimate Enrollment Assumptions Best Estimate Trend Assumption								
	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	**$68.0**	**$141.2**	**$151.5**	**$160.3**	**$167.9**	**$175.9**	**$184.2**	**$1,049.0**
State share	$0.6	$1.3	$1.6	$5.8	$10.9	$13.2	$17.4	$51.0
Federal share	$67.4	$139.9	$149.9	$154.5	$157.0	$162.7	$166.7	$998.0
Newly Eligible Children	**$10.1**	**$22.4**	**$26.3**	**$28.6**	**$29.9**	**$31.3**	**$32.8**	**$181.4**
State share	$4.4	$9.5	$10.2	$10.2	$10.7	$11.6	$13.5	$70.2
Federal share	$5.7	$12.9	$16.1	$18.3	$19.2	$19.7	$19.3	$111.2
Woodwork (Adults and Children)	**$23.0**	**$45.3**	**$44.7**	**$45.9**	**$48.1**	**$50.4**	**$52.8**	**$310.2**
State share	$11.5	$22.6	$22.4	$23.0	$24.1	$25.2	$26.4	$155.1
Federal share	$11.5	$22.6	$22.4	$23.0	$24.1	$25.2	$26.4	$155.1

Table A8 – Projected Cost of Full ACA Expansion Population, FY 2014 to FY 2020 ($MM) High Estimate Enrollment Assumptions Low Estimate Trend Assumption								
	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	**$64.1**	**$131.9**	**$138.8**	**$144.1**	**$148.0**	**$152.0**	**$156.1**	**$935.0**
State share	$0.5	$1.2	$1.5	$5.2	$9.6	$11.4	$14.8	$44.3
Federal share	$63.6	$130.6	$137.3	$138.9	$138.3	$140.6	$141.3	$890.7
Newly Eligible Children	**$9.5**	**$20.9**	**$24.0**	**$25.7**	**$26.4**	**$27.1**	**$27.8**	**$161.4**
State share	$4.1	$8.9	$9.3	$9.2	$9.5	$10.0	$11.5	$62.5
Federal share	$5.4	$12.0	$14.7	$16.5	$16.9	$17.1	$16.3	$98.9
Woodwork (Adults and Children)	**$21.7**	**$42.3**	**$41.0**	**$41.3**	**$42.4**	**$43.5**	**$44.7**	**$276.9**
State share	$10.8	$21.2	$20.5	$20.6	$21.2	$21.8	$22.4	$138.5
Federal share	$10.8	$21.2	$20.5	$20.6	$21.2	$21.8	$22.4	$138.5

Table A9 – Projected Cost of Full ACA Expansion Population, FY 2014 to FY 2020 ($MM) High Estimate Enrollment Assumptions High Estimate Trend Assumption								
	2014	2015	2016	2017	2018	2019	2020	Total
Expansion Adults	**$72.0**	**$151.0**	**$165.2**	**$178.1**	**$190.1**	**$202.9**	**$216.6**	**$1,175.8**
State share	$0.6	$1.4	$1.8	$6.5	$12.4	$15.2	$20.6	$58.5
Federal share	$71.4	$149.6	$163.4	$171.6	$177.7	$187.7	$196.0	$1,117.3
Newly Eligible Children	**$10.7**	**$24.0**	**$28.6**	**$31.7**	**$33.9**	**$36.1**	**$38.6**	**$203.6**
State share	$4.7	$10.2	$11.1	$11.4	$12.1	$13.4	$15.9	$78.7
Federal share	$6.0	$13.8	$17.6	$20.3	$21.7	$22.8	$22.6	$124.9
Woodwork (Adults and Children)	**$24.3**	**$48.4**	**$48.7**	**$51.0**	**$54.5**	**$58.1**	**$62.1**	**$347.1**
State share	$12.2	$24.2	$24.4	$25.5	$27.2	$29.1	$31.0	$173.6
Federal share	$12.2	$24.2	$24.4	$25.5	$27.2	$29.1	$31.0	$173.6